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ABSTRACT

Delivery of health care services is under close national scrutiny -- and rightly so! This report examines one facet of those traditional services, inpatient specialty consultation, in the form of 100 consecutive initial requests for child psychiatry consultative assistance in the clinical setting of a large children's hospital. Analysis of the data in the usual categories (age, sex, race, fee, service, and diagnosis) would strongly suggest that the consultative process is highly complex and only partially, at best, responsive to the needs of patients. Clusters of other significant variables which alter the process include attitudes of the patient and his family, the consultant, the consulee and other staff members, hospital institutional practices, and community and social influences. It would perhaps be more colorful to conclude that inpatient psychiatric consultation for children constitutes a symptom of the national non-system of health care delivery. Accuracy would require rather the conclusion that there is after all a kind of system, but that it is largely hidden, inefficient and too often hypocritical. (Author)

PSYCHIATRIC CONSULTATION WITHIN A COMMUNITY OF SICK CHILDREN -- LESSONS FROM A CHILDREN'S HOSPITAL

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Summary and Conclusion

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PSYCHIATRIC CONSULTATION WITHIN A COMMUNITY OF SICK CHILDREN -- LESSONS FROM A CHILDREN'S HOSPITAL

Introduction

The mounting public concern over the delivery system, cost, and effectiveness of modern health care is long overdue. As always, collective self-examination and social upheaval entail the risk of dispatching the babe with the bath water down the proverbial tube. But it is a risk that must be run, not the least reason for which is that there is no realistic alternative. Nor is there time for endless refinements and discriminations. A few navels will inevitably be pinched in an effort to get the lint out. Perhaps the most constructive contribution that could be made by those of us who live off the health care game would be, rather than evasive action, to lead the self-examination process in those areas where we have most experience.

Purpose

This paper aims at reporting the examination of a very small, but basic element in traditional health care, i.e., specialty consultation within a hospital setting. The data are drawn from a selective sample of 100 consecutive initial requests for inpatient child psychiatric consultation within a large children's medical center. All of the requests were answered personally and in writing by the author over a period of 14 months (July, 1968 through August, 1969), during which time I saw approximately 10 per cent of the children for whom specialty consultation(s) were sought throughout the hospital.

Analysis of these data is directed at better understanding of the process whereby inpatient consultative assistance is requested and delivered.

Obvious caution must be exercised in view of sample size, age of patients, the particular specialty involved, etc. Yet one must begin somewhere. Effort is made here to identify findings worthy of note concerning the specific patient sample, and then to delineate clusters of variables which seem to significantly influence the consultative process. Hopefully, identification of the relevant variables may then permit more meaningful analysis of larger samples in a variety of settings.

Method

The methodology employed here was exclusively that of clinical research combined with professional care (Helsinki Declaration).[4] The operational definition of an "initial consultation request" was the first formal written request by a staff physician that an inpatient child be seen by the psychiatry consultant. Every such request received a written response. Follow-up visits or readmissions of the same child, as well as informal inquiries about other children, were not included in the sample. All of the data analysis was conducted ex post facto and no effort whatsoever was made to deliberately structure or otherwise influence consultation requests. Presumably they reflect need in the clinical judgment of over four hundred attending staff and seventy house staff physicians. Consultative responses were similarly determined exclusively by the potential therapeutic advantage to the child-patient and his family.

The "typical hospital" setting will be recognized immediately by any practicing physician, but its virtues and vices deserve a further word with reference to the more thorough-going scientific methodologist. Neatness of design is knowingly sacrificed in order to obtain the more full-bodied flavor of "like it is." For example, controls are not matched, but are more randomly

clinical in the sense of my awareness and involvement in other cases within the same setting, but which did not lead to a formal consult request. There is no question about the usefulness of the purer design, but rather one of timing. First one must "hunch out" the relevant variables and the answerable questions, and here the everyday clinician may have the advantage; then one can "hone in" on critical details which make or break validity and reliability, and there the research methodologist shines. Let it be clear that the following constitute some clinical hunches.

Setting

Since the physical setting is among the more obvious determinants of events, a few comments about The Children's Orthopedic Hospital and Medical Center are in order. The institution was privately founded in Seattle in 1907 and was originally responsive to the needs of crippled children. Within only four years, however, a general children's hospital was created which has now grown to over two hundred beds and which provides in- and out-patient services in virtually every medical-surgical-dental specialty. Thus, one must not be misled by the historical title "The Orthopedic," for the present institution is truly a medical center for children from birth to twenty-one years of age. The hospital is the primary training unit in the pediatric specialties within the University of Washington School of Medicine. The medical staff is composed of over four hundred physicians, the vast majority of whom are in private practice and admit private patients to the hospital, and also teach and serve voluntarily in the wards and clinics. There are presently 17 physicians, including the author, who are based full-time within the Hospital. In addition, approximately seventy interns, residents, and fellows spend at least some time in the hospital during a year. Almost 10,000 children were admitted during the past year, of whom approximately 60 per cent

were billed full fees ("private"), 20 per cent only the amount of insurance coverage available ("limited coverage"), and 20 per cent no fee whatsoever ("house"). Over 53,000 visits to outpatient clinics were recorded by 37,000 children, of whom only 17 per cent were rated as private.

The present hospital building, first occupied in 1953, is located in a fashionable, upper-middle-class neighborhood that is adjacent to the University of Washington campus and populated by many faculty and other professional persons. Although geographically located only ten to fifteen minutes travel time from the urban core, it is sociologically quite removed in many demonstrable ways such as property value, population density, racial composition, and the like. The physical layout of the wards reflects hospital architecture of the early 1950's. There are long corridors, a nursing station midway down the hall, and (with the exception of the infant unit) principally single rooms and four-bed wards.

Child psychiatry has been represented within the hospital program for approximately twenty years by the voluntary services of a few child psychiatrists in practice in the community. In recent years, the psychiatry staff has grown to about twenty members, most of whom volunteer time on a rotational basis and provide a variety of services such as supervision, case conferences, and occasional ward consultations. In 1967, a full-time child psychiatry department was established and, as staff gradually expanded, began to offer a number of new services. The latter point is particularly relevant in that the present data sample represents the first fourteen months during which ward consultations were answered by a full-time, hospital-based child psychiatrist. The result has been an approximately ten-fold increase in the frequency of formal consult requests.

Findings

(1) Age

COMPARISON (BY AGE) OF CONSULTATION AND ADMISSION RATES

Age (Years)	Consultations (%)	Admissions (%)
Under 1	2	19.8
1 - 2	5	19.4
3 - 4	3	14.8
5 - 11	27	33.0
12 - 13	15	5.6
14 - 18	47	6.7
19 - 21	1	0.7

CONSULTATION RATES BY YEAR OF AGE

Age (Years)	Consultations (%)	Age (Years)	Consultations (%)
Under 1	2	11	6
1	1	12	6
2	4	13	9
3	1	14	14
4	2	15	17
5	1	16	10
6	1	17	4
7	2	18	2
8	6	19	1
9	5	20	0
10	6	21	0

In general, the children fall into four major age groupings: 0-7, during which the rate was about 2 per cent of referrals per year of age; 8-12, when the rate was about 6 per cent; 13-16, when there was a very sharp peak to 17 per cent of referrals at age 15 alone; and, 17-20, during which there was a steep decline literally to zero. The prominence of the referral rate of adolescents is even more striking when contrasted with the admission rate by age for the same period. Thus, whereas children 12-21 constituted only 13 per cent of hospital admissions, 63 per cent of psychiatric consultation requests were concerned with this age group.

Several thoughts occur in response to this finding: (a) the age distribution is remarkably similar to the total numbers of children served in psychiatric facilities throughout the nation, including outpatient clinics and state and county mental hospitals, as reported by NIMH.[7] Those data, for example, indicate that the age group 10-17 comprised two-thirds of the estimated 473,300 children served during 1966, the most recent year for which data are available. In view of such a high concentration of younger age children as reflected in the hospital admission rates, however, one might reasonably expect a skew in that direction when drawing upon the hospital population. Instead, one finds the age rates very comparable to the general population, despite the national findings that younger children were referred most frequently by physicians. (b) Age distribution of consult requests would also clinically seem to reflect the developmental style in which problems are presented. Careful observation on the wards would certainly support the impression of many, many problems and potential problems among the infants and younger children, but these are presented in such a way that they can be easily denied or suppressed even by a staff of child-care workers. The adolescent group is more prone to present themselves in a

loud or dramatic manner which more often arouses or even antagonizes the staff. (c) And closely akin to the developmental style of the patient is an even less tangible quality of developmental tolerance on the part of a children's hospital staff. There is frequent evidence of the staff need to nurture and support in the sense of "babying" a child, but it is often accompanied by an equally strong wish to be appreciated in return. It is the latter need which may limit tolerance for the adolescent developmental tendency to demand independence and often fiercely deny dependence. One hears frequently staff reference either to unresolved adolescent conflicts of their own which may still be the source of frustration, or to current difficulties in management of their own presently adolescent children. Perhaps the finding that age rates of psychiatric referral much more closely parallel the general population rather than the hospital population reflects a commonality in those referring the children, rather than actual need on the part of the children themselves.

(2) Sex

COMPARISON (BY SEX) OF CONSULTATION AND ADMISSION RATES

Sex	Consultations (%)	Admissions (%)
female	52	42.2
male	48	57.8

Despite the definite predominance of males hospitalized, the trend was reversed in the referrals of males for psychiatric consultation. This finding is the opposite of what one would predict based not only on admission rates, but also on virtually all of the statistical reports of psychiatric service for children. The NIMH report[7], for example, indicates that twice as many boys as girls were given service in the 2,122 clinics reporting. There is a trend, however, toward serving more adolescent girls in general hospitals.

Why should females constitute the majority of psychiatric referrals in a children's hospital setting? Several clinical observations seem pertinent: (a) in view of the heavy predominance of adolescents, and in view of the medical setting, the finding is probably determined at least in part by the greater acceptability of somatization by females in our social structure, especially during the somewhat flamboyant years immediately following pubescence. The finding is even more understandable after analysis of the complaints and diagnostic groupings such as possible CNS disease versus suspected conversion. (b) Yet another staff consideration is the fact that, in significant measure, a children's hospital is largely a community of women (nurses, aides, volunteers, trustees, para-medical staff, and many of the physicians). These women, who may often instigate a referral, seem much more sensitively attuned to the psychosocial dilemmas of other younger women, i.e., the adolescent girls. (c) In a psychoanalytic vein, one can at least speculate about possible transference implications of professional working relationships between the female staff members and a male psychiatric consultant in this setting. Several instances have suggested both a vicarious enjoyment of the consultative process especially by nurses, and a deliberate enhancement of the "mutual parenting" aspect inherent in follow-up inpatient management. The consultant must be alert to his own role and counter-transference in fostering such referrals.

(3) Race

COMPARISON (BY RACE) OF CONSULTATION AND ADMISSION RATES

Race	Consultations (%)	Admissions (%)*
Caucasian	94	94.9
Negro	3	2.7
Indian	3	1.3
Oriental	0	1.1

*1964 most recent year for which data available

Record-keeping concerning race has been so influenced in recent years by social action pressures that we paradoxically have perhaps the least valid, and certainly the least current data on what remains one of our greatest problem areas. The NIMH study[7], for example, relied most heavily on a 1961 study, and further noted that much of the data were reported by clinics in the South and thus might not be nationally representative. The hospital from which our present data are drawn ceased recording race in 1964, and we are forced to assume that present racial admission rates are similar. If this is true, one is struck principally by the close parallel of admission and consultation rates for blacks and whites, and the somewhat larger number of Indians and absence of Orientals.

It is tempting to point to these findings as proof of the absence of any discrimination, particularly when one can document the fact that the percentage of admission of black patients is virtually identical to the percentage of black population in the geographical area principally served. In 1967, blacks constituted 7 per cent of the Seattle population, but only about 4 per cent of King County. From a different viewpoint, however, might these same statistics be interpreted as confirmation of the charge of the Commission on Civil Disorders[6] that "white institutions maintain it (the ghetto)." Thus, how is it that a health care institution in an American urban setting that prides itself on service to the indigent would serve no more than the general population percentage of black children? The issue is undoubtedly complex and the number of relevant variables great, yet the question stands. Surely one might expect admission rates of black children to such an institution to far exceed the general population.

Furthermore, apart from admission rates, what about referral of minority groups for psychiatric consultation in this setting? It must be noted that

the professional staff is composed of considerably less than 1 per cent of non-caucasions. Clinical observation would suggest that staff sensitivity to certain minority group difficulties is less than optimal, and further that there is reluctance to call a psychiatrist who is too often viewed as oriented toward and able to treat only the McWASP (middle class, white, Anglo-Saxon, Protestant) syndromes. The psychiatric profession must accept no small share of responsibility for the latter phenomenon. Finally, one is led to speculate that perhaps most of the black children admitted are often drawn from the Seattle Urban League's[8] estimated 4.2 per cent of the Negro population said to be integrated in the "free choice" patterns enjoyed by the population at large.

(4) Fee Category

COMPARISON (BY FEE CATEGORY) OF CONSULTATION AND ADMISSION RATES

Fee Category	Consultations (%)	Admissions (%)
Private	50	58.3
Insurance Coverage Only	12	20.8
Free Care	38	20.9

Since insurance coverage so seldom allows for psychiatric consultation, one can for practical purposes think in terms of two fee categories, private and non-private. Findings indicate that the two are quite comparable in overall admission and psychiatric consultation rates. In view of the obviously crucial importance of economic factors in health care delivery, however, it must be emphasized that this section of the present study constitutes probably the least valid reflection of the consultative process. The reason lies in the fact that the consultant is a salaried employee of the hospital and although permitted to bill private patients, was not

forced to do so for income purposes. The result was billing at a very minimal rate or no billing whatsoever in the face of any evident hardship. Thus, the consultee could safely assume no significant additional financial burden would be placed upon a private patient for whom psychiatric consultation was sought. Confirmation of the probable importance of this factor has been found subsequent to the period of this study when a policy was instituted whereby private patients were seen in consultation by outside private practicing child psychiatrists. The result was a fall in referral rate of private patients to less than half the former rate. It would certainly appear that concern about cost is a very major factor, as well as need, in requesting psychiatric assistance.

(5) Service

COMPARISON (BY SERVICE) OF CONSULTATION AND ADMISSION RATES

Service of Origin	Consultations (%)	Admissions (%)
Medical	84	53.3
Surgical	16	46.7

Whereas the admission rates for the medical and the surgical services, including the various sub-specialties within each, are essentially similar, there is a predominance of over five consult requests from medical services to one from surgical services. Why? The old saw that surgeons as a breed are simply blind to psychological factors is overworked and quite likely more mythical than true. (a) A number of rather obvious facts come immediately to mind such as the shorter average hospital stay of surgical patients, the frequently precipitous nature of surgical illness, and the acutely dramatic manner in which the surgical management tends often to focus

attention on the offending part more than the whole patient. In addition, one can easily rationalize and interpret many emotional problems as exclusively reactive to the surgical illness and intervention, and then comfortably assume they will go away upon recovery. Note that, in the main, it is the surgeon who actively intervenes, while the child rather passively gets well. (b) On the other hand, it is more often the medical specialties which must cope with the chronic diseases that so often take such a high psychological toll. Diabetes, asthma, cystic fibrosis, mental retardation, seizure disorders, leukemia, congenital defects, and others come immediately to mind. It is much more difficult to avoid the whole child, including his understanding of his own illness, his emotional reaction to it, and perhaps even his own participation in its treatment. The child himself may even demand to see a "shrink," a term of only superficial and defensive depreciation, but often covering a deep-seated plea for fuller understanding on the part of the caretakers. (c) And again it is principally the medical specialties, particularly pediatrics and neurology, which fall heir to those perplexing diagnostic problems wherein one is hard-pressed to know whether there is any sort of detectably organic disease at all and, if so, to what extent it may be psychologically induced or perpetuated. (d) Finally, although I have already defended my surgical colleagues against the churlish charge of insensitivity, I should not imply that I think there are no psychologically significant differences between the two referring groups.[3] It would seem to me more nearly inherent in practice of the medical specialties that one must be impressed by such factors as placebo effect, power of suggestion, unreliability of much history-taking, infrequency with which patients actually follow specific prescriptions (yet still recover!), etc. Perhaps such a practitioner must more often consider the psychosocial aspects of a health care problem.

(6) Diagnosis

Diagnostic Grouping	Consultations (%)
(A) Psychological reactions leading to self-inflicted injury or illness	19
1. Suicide attempts (14)	
2. Drug abuse (5)	
(B) Psychological reactions with associated changes in bodily function	20
(C) Psychophysiological (vegetative) reactions	14
(D) Mixed conversion and psychophysiological reactions	6
(E) Psychological reactions to physical disorders	32
1. Reactions to physical disorders involving primarily the CNS (14)	
2. Reactions to physical disorder outside CNS (18)	
a. Acute illness or injury (2)	
b. Chronic illness or handicap (16)	
(F) Psychological reactions only	9

Discussion of the many intricate problems of psychiatric diagnosis in children is well beyond the scope of this report. The basic frame of reference presented, with only slight modification, is taken directly from Prugh's classic essay on psychosomatic concepts in relation to illness in children.[5]

Several of these findings deserve special mention. (a) The national data concerning the high incidence of suicide attempts, especially in the mid-adolescent years[1], would seem confirmed. It might be noted that many of these represented genuinely serious attempts such as hanging, gunshot wounds of

the head, massive overdosage, and intentional major automobile accidents. (b) A less heralded area of mounting significance is that of emotional sequelae of chronic disease in children, whether of the central nervous system or other organ systems. Traditional institutional practice is to acknowledge the importance of these psychological reactions, but then to largely ignore them in the day-to-day management planning. The psychiatric consultant should certainly be able to assist in providing such a child an age-appropriate understanding of his own illness and its treatment, educational and recreational planning, and implementing some other rehabilitative procedures, like re-motivation and operant conditioning techniques. (c) An obviously common problem is that of first teasing apart, and then reconstructing a fuller understanding of psychological reactions and associated changes in bodily function. Unfortunately, the psychiatrist sequestered in his office has too often given the impression of a wish to evade the aspect of bodily function. One result has been the abuse of hospitalization wherein a child might be admitted to the hospital simply in order to obtain consultative assistance which could as effectively have been provided on an out-patient basis.

Discussion

As indicated at the outset, the principal concern of this report is the process of inpatient consultative health care delivery and the major variables which influence that process. There is a comforting myth that the needs of patients constitute the main, if not the sole basis for medical care. At least in the area of my own experience, this is wishful thinking. The system is vastly more complex and human, but distinctly less humane. Several clusters of relevant variables include the following:

(1) Patient/family variables. Obviously, there is no attempt to pretend that the specific needs of the individual identified patient are irrelevant. But so many other elements must be considered. For example, family attitudes toward the very existence of emotional problems, how they may be viewed as reflecting on the family, and the implications of psychiatric help may all play a role in consultation. I have been involved in some situations where the parents initiated and demanded psychiatric consultations over the objections of the attending physician, and in others where I was approached (unsuccessfully) to see a child surreptitiously so that the objecting parents would not find out about it. Some of the outright lies children are told about hospitalization or their illnesses are the occasion for clearly preventable psychiatric problems. The family economic status is a very common determinant that too often runs counter to patient need. In most settings where fee-for-service is the economic rule, there is presumably discrimination against the poor. In this setting it is interesting to note at least occasional paradoxical discrimination against the middle income family where, unless there is adequate insurance coverage, consultation may not be sought in an effort to reduce an invariably large hospital bill. The so-called "house" case, of course, pays no hospital bill.

(2) Consultant variables. The child psychiatry consultant himself determines in some measure the nature of the process, perhaps most obviously by his willingness or unwillingness to even see inpatients at all in a medical-surgical setting. Even when theoretically available, the visibility of the consultant is another factor. One can almost titrate the flow of consult requests by spending more or less time on the wards, making rounds, discussing problems informally with

physicians and nurses, etc. Once requested to see a patient, the consultant then determines how soon he may be asked to see another patient in the future by the promptness of his response, evidence of at least the pertinent basic medical knowledge, and ability to translate his psychosocial understanding of the patient and family into succinct statements and specific recommendations, preferably in plain English and free of jargon.[2] Offer of follow-up collaborative care, when indicated, is especially important when it is coupled with consultant knowledge of the ward milieu and how it can best be utilized to the patient's benefit. Unfortunately, one phenomenon that must be guarded against is the overly compliant consultant who may be called on often to predictably rubber-stamp the opinions of the primary physician. In such cases the physician is being treated rather than the patient. And just as the economic status of the patient is a variable, so is it true of the consultant. Only a salaried consultant could afford to see large numbers of non-paying patients.

(3) Consultee/staff variables. An integral part of the myth that patient needs exclusively determine request for consultative assistance is the notion that all physicians are equally sensitive to the psychological problems of their patients, and equally ready to seek assistance when needed. In no other area may the physician's own problems more likely get in the way of effective care. This may show itself by unnecessary consultation request as much as by failure to seek help. His training vintage may also be reflected in his use of psychiatric consultation as well as his relative emphasis on "the disease" versus "the patient-and-his-family." Individual variation in tolerance of behavior at different stages of child and adolescent development has already been noted. Not infrequently, for example, one hears the notion that "common sense"

is good enough for the pre-adolescent child, but the adolescent may need a psychiatrist. There is also periodic staff confusion and ignorance of the roles of child psychiatrist, psychologist, social worker, chaplain, occupational therapist, etc. Finally, there is the age-old problem of psychiatric diagnosis by medical exclusion alone, rather than the possible use of a consultant to assist in diagnosis by positive data.

(4) Hospital/institutional variables. Many of the variables already noted owe their origins to institutional tradition, some of which have unquestionably outlived their usefulness. For example, sometimes hospital rules prohibit the persons (e.g. nurses, aides, volunteers, recreation therapists, etc.) who observe and guide the child's behavior in a sustained manner from seeking psychological assistance, while insisting that the persons (physicians) who probably see the patient least in the hospital be the ones to seek such help. This problem is closely related to yet another one of hospital administration, namely, the gargantuan issue of relationships among various departments, i.e. the power structure. One may safely assume there need be structure, but presently only the rash and the inexperienced would suggest that it is predominantly and effectively oriented toward patient-care in most hospitals. Issues such as cost, space, statistics, grants, and the like assume a subtle, yet very influential life of their own, rather quickly permeate institutional procedures, and definitely affect provision of patient services such as inpatient consultation.

(5) Community/social variables. Although often vaguely defined, yet another set of variables has to do with community practices and societal guidelines such as legislation. At a national level, for example, Medicaid legislation, the

NIMH sponsorship of the community mental health center concept, and the recommendations of the Joint Commission of Mental Health of Children all have direct bearing on the psychiatric consultative process. There is seemingly endless talk of the need for comprehensiveness and continuity of care for sick and disturbed children, yet the disorganization, competitiveness, and ineffectiveness of child welfare services in most urban communities is appalling. At the beginning of the study period covered by this report, one of the more common arguments I heard against seeking obviously needed psychiatric consultation was the assumption that the consultant would then simply recommend follow-up care which was either unavailable or well beyond the means of a given family. Prior experience indicated that the argument was not without some foundation. Fads and shibboleths are also among our communal enemies. In our current emphasis on community consultation and prevention, it is occasionally difficult to find someone to treat the child who has already fallen ill, particularly if it cannot be accomplished hurriedly. Such a system is out of balance.

Summary and Conclusion

Delivery of health care services is under close national scrutiny -- and rightly so! This report examines one facet of those traditional services, inpatient specialty consultation, in the form of 100 consecutive initial requests for child psychiatry consultative assistance in the clinical setting of a large children's hospital. Analysis of the data in the usual categories (age, sex, race, fee, service, and diagnosis) would strongly suggest that the consultative process is highly complex and only partially, at best, responsive to the needs of patients. Clusters of other significant variables

which alter the process include attitudes of the patient and his family, the consultant, the consultee and other staff members, hospital institutional practices, and community and social influences. It would perhaps be more colorful to conclude that inpatient psychiatric consultation for children constitutes a symptom of the national non-system of health care delivery. Accuracy would require rather the conclusion that there is after all a kind of system, but that it is largely hidden, inefficient, and too often hypocritical.

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